Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ZALE LIPSHY UNIVERSITY HOSPITAL
PO BOX 201345
ARLINGTON TX 76006-1345

Respondent Name
AMERICAN INSURANCE COMPANY

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-98-B375-01

MFDR Date Received
April 27, 1998

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The date of service 9-16-97 thru 9-21-97 did not pay correctly under the per diem guidelines adopted August 1, 1997."

Amount in Dispute: $19,149.86

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Bills were properly paid pursuant to the per diem rates and provisions of the 1992 Acute Care Inpatient Hospital Fee Guideline. . . . While the Guideline was invalidated as a TWCC rule based upon procedural errors in its adoption, the per diem rates and methodology of the Guideline are a valid measure of fair and reasonable hospital fee reimbursement for acute care inpatient treatment."

Response Submitted by: Flahive, Ogden & Latson, 505 West 12th Street, Austin, Texas 78701

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
September 16, 1997 to September 21, 1997	Inpatient Hospital Services	$19,149.86	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. Former 28 Texas Administrative Code §133.305, effective June 3, 1991, 16 *Texas Register* 2830, sets out the procedures for resolving medical fee disputes.
2. Former 28 Texas Administrative Code §134.401, effective August 1, 1997, 22 *Texas Register* 6264, sets out the fee guidelines for acute care inpatient hospital services.
3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - F – Reduced According to Fee Guideline
   - 480 – REIMBURSEMENT BASED ON THE ACUTE CARE INPATIENT HOSPITAL FEE GUIDELINE PER DIEM RATE ALLOWANCES.
   - G – Include in Global
   - 226 – INCLUDED IN GLOBAL CHARGE

Findings

1. Former 28 Texas Administrative Code §133.305(d)(7), effective June 3, 1991, 16 *Texas Register* 2830, requires that the request shall include "copies of all written communications and memoranda relating to the dispute." Review of the documentation submitted by the requestor finds that the request does not include copies of any medical records to support the services in dispute or copies of any supply invoices to support the cost to the hospital of disputed implantable items. The Division concludes that the requestor has not met the requirements of §133.305(d)(7).
2. The respondent's position statement asserts that a "PPO reduction was made in addition to the reduction to a fair and reasonable amount according to the fee guideline methodology." Review of the submitted explanations of benefits finds no reason codes were used to indicate that a PPO reduction was taken. Review of the submitted information finds insufficient documentation to support that a PPO reduction or contractual fee arrangement is applicable to the services in dispute. The services will therefore be reviewed for payment in accordance with applicable Division rules and fee guidelines.
3. This dispute relates to inpatient hospital services with reimbursement subject to the provisions of the Division's former *Acute Care Inpatient Hospital Fee Guideline* at 28 Texas Administrative Code §134.401, effective August 1, 1997, 22 *Texas Register* 6264. Review of the submitted documentation finds that the length of stay was 5 days, including one day of treatment in the intensive care unit. The type of admission is surgical; therefore, the per diem for one ICU day of $1,560 plus four days at the standard surgical per diem amount of $1,118.00 yields a reimbursement amount of $6,032.
4. Per §134.401(c)(4)(A)(i), implantables (revenue codes 275, 276, and 278) shall be reimbursed at cost to the hospital plus 10%. The requestor's medical bill indicates that the health care provider billed revenue code 278 for 2 units at $2,870.00. However, review of the submitted documentation finds no description of the disputed implantable items, no medical records to support the items as billed, and no purchase orders, supply invoices or other information to support the cost to the hospital of the disputed implantable items. The Division concludes that the requestor has not provided sufficient information to support the request for reimbursement of the disputed implantable items; therefore, additional payment for implantables cannot be recommended.
5. Additionally, review of the submitted records finds that the health care provider billed for pharmaceuticals exceeding $250.00 per dose. Per §134.401(c)(4)(C) "Pharmaceuticals administered during the admission and greater than $250 charged per dose shall be reimbursed at cost to the hospital plus 10%." However, review of the submitted documentation finds no documentation to support that any pharmaceuticals were administered exceeding $250.00 per dose. Nor was any documentation found to support the cost to the hospital of the disputed pharmaceuticals; therefore, additional payment for pharmaceuticals cannot be recommended.
6. The total recommended reimbursement for the services in this dispute is $6,032. This amount less the amount previously paid by the insurance carrier of $7,242 leaves an amount due to the requestor of $0.00. No additional reimbursement is recommended for the services in dispute.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under 28 Texas Administrative Code §133.305. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Grayson Richardson Medical Fee Dispute Resolution Officer	February 8, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.